Benefit Provision		CMG High	CMG Low	OAPIN	OAP High		OAP Low		Choice Fund	
		I.	n-Network Coverage Onl	у	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Deductible (These work differently for CMG, OAP and HSA Plans. See Plan Deductibles & Out-Of-Pocket Maximums Section for details.)	Single	\$250 Facility Deductible	\$300 Facility Deductible	\$250 Annual Deductible	\$350 Annual Deductible	\$700 (one way accumulation)	\$500 Annual Deductible	\$1,000 (one way accumulation)	\$1,200 (cross accumulated) Annual Deductible; \$500 contribution by Maricopa County to your HSA	
	Family	\$500 Facility Deductible	\$600 Facility Deductible	\$500 Annual Deductible	\$700 Annual Deductible	\$1,400 (one way accumulation)	\$1,000 Annual Deductible	\$2,000 (one way accumulation)	\$2,400 (cross accumulated) Annual Deductible; \$1,000 contribution by Maricopa County to your HSA	
Standard Percent of Co-insurance		N/A	10%	N/A	N/A	30% of max reimbursable charge	10%	30% of max reimbursable charge	10%	30% of max reimbursable charge
Out-of-Pocket Maximum (See the Out-of-Pocket Section for details)	Single	\$1,000	\$5,000	\$1,500	\$2,000	\$4,000	\$5,000	\$10,000	\$2,000 (cross accumulated)	\$2,000 (cross accumulated)
	Family	\$2,000	\$10,000	\$3,000	\$4,000	\$8,000	\$10,000	\$20,000	\$4,000 (cross accumulated)	\$4,000 (cross accumulated)
Pre-existing Condition Limitation		None	None	If 19 or older, 12 months if treatment was received in prior 90 days. Waived (on month by month basis) with Certificate of Creditable Coverage and for employees & dependents currently covered by a County medical plan for at least 12 months. Certificate of Creditable Coverage must be sent to CIGNA.						
Preventive Care		\$0 (FREE)	\$0 (FREE)	\$0 (FREE)	\$0 (FREE)	Covered in-network only	\$0 (FREE)	Covered in-network only	\$0 (FREE) no deductible	Covered in-network only
Primary Care Physician Services ¹		\$25	\$35	\$30	\$35	30% after deductible	\$45	30% after deductible	10% after deductible	30% after deductible
Convenience Care Clinic Visit		\$15	\$25	\$20	\$25	30% after deductible	\$35	30% after deductible	10% after deductible	10% after deductible
Specialty Care Physician Services - CCN/Non-CCN		\$35* / \$50**	\$55* / \$70**	\$40* / \$55**	\$45* / \$60**	30% after deductible	\$60* / \$75**	30% after deductible	10% after deductible	30% after deductible
Advanced Radiological Imaging: CT, PET, MRI, MRA Scans/type of scan/day and nuclear cardiac studies**		\$50/type of scan/day***	\$100/type of scan/day***	\$100/type of scan/day***	\$100/type of scan/day***	30%***	10%***	30%***	10% after deductible	30% after deductible
Allergy Injections - PCP/CCN;Non-CCN		\$13* / \$28**	\$18* / \$33**	\$15* / \$30**	\$18* / \$33**	30% after deductible	\$23* / \$38**	30% after deductible	10% after deductible	30% after deductible
Independent Lab and X-ray facility		\$0	\$0	\$0 after deductible	\$0 after deductible	30% after deductible	10% after deductible	30% after deductible	10% after deductible; \$0, no deductible if preventive	30% after deductible
Inpatient Hospital Facility Services (including delivery)	5	\$50/day, 5 day max, after deductible	\$150/day, 5 day max, plus 10% after deductible	\$200/admit, after deductible	\$250/admit, after deductible	30% after deductible	\$1,000/admit, plus 10% after deductible	\$2,000/admit plus 30% after deductible	10% after deductible	30% after deductible
Inpatient and Outpatient Professional Services (Surgeon, Radiologist, Anesthesiologist, Pathologist)		\$0	\$0	\$0 after deductible	\$0 after deductible	30% after deductible	10% after deductible	30% after deductible	10% after deductible	30% after deductible
Outpatient Hospital Facility Services	\$	100 after deductible	\$250 plus 10% after deductible	\$100 after deductible	\$150 after deductible	30% after deductible	\$500 + 10% after deductible	\$1,000 + 30% after deductible	10% after deductible	30% after deductible
Pre- & Post-natal Exams (after pregnancy has been determined)	\$	335* / \$50**, waived after 1st visit	\$55* / \$70**, waived after 1st visit	\$40* / \$55**, waived after 1st visit	\$45* / \$60**, waived if admitted to hospital	30% after deductible	\$60* / \$75** + 10%	30% after deductible	10% after deductible	30% after deductible
Urgent Care (Copay reimbursed if referred directly to Emergency Room)	ā	\$75, waived if admitted to hospital	\$75, waived if admitted to hospital	\$75, waived if admitted to hospital	\$75, waived if admitted to hospital	\$75, waived if admitted to hospital	\$75, waived if admitted to hospital	\$75, waived if admitted to hospital	10% after deductible	10% after deductible
Emergency Room		\$175, waived if admitted	\$175, waived if admitted	\$175, waived if admitted	\$175, waived if admitted	\$175, waived if admitted	\$175, waived if admitted	\$175, waived if admitted	10% after deductible	10% after deductible
Ambulance		\$0	\$0	\$0 after deductible	\$0 after deductible	\$0 after deductible	10% after deductible	10% after deductible	10% after deductible	10% after deductible
Durable Medical Equipment/Medical Supplies No annual limit (copay applies to each item)		\$75 DME; \$0 consumable supplies	\$75 DME; \$0 consumable supplies	\$75 DME after deductible; \$0 consumable supplies after deductible	\$75 DME after deductible; \$0 consumable supplies after deductible	30% after deductible	\$75 + 10% DME after deductible; \$0 consumable supplies after deductible	30% after deductible	10% after deductible	30% after deductible
External Prosthetics		\$0	\$0	\$0 after deductible	\$0 after deductible	30% after deductible	10% after deductible	30% after deductible	10% after deductible	30% after deductible
Chiropractic Services, Pulmonary Rehab, Physical, Speech, Occupational and Cognitive Therapy 120 vis maximum combined/yr. except as noted	sits	\$25**/provider per day****	\$35**/provider per day****	\$30**/provider per day	\$35**/provider per day	30% after deductible/ provider per day	\$45**/provider per day	30% after deductible/ provider per day	10% after deductible/ provider per day	30% after deductible/ provider per day
Cardiac Rehab; 36 visits/yr.		\$25** per visit	\$35** per visit	\$30** per visit	\$35** per visit	30% after deductible	\$45** per visit	30% after deductible	10% after deductible	30% after deductible
Alternative Medicine; 20 visits/yr. Maximum; \$60 credit for supplies/products		Same as PCP copay	Same as PCP copay	Same as PCP copay	Same as PCP copay	Covered in-network only	Same as PCP copay	Covered in-network only	\$10% after deductible	Covered in-network only
Behavioral Health/Pharmacy		1	Magellan/WHI				gellan/WHI		CIGNA Behavioral Hea	llth/CIGNA Pharmacy
For more detail, review the plan summaries on the Benefits Home Page under the Open Enrollment tab, Medical Section or the CIGNA tab, or compare plans on www.mycignaplans.com User ID: maricopacounty2011 and Password: cigna *You pay lower copays when you use a specialist with the CIGNA Care Network (CCN) designation; for more information see the Glossary of Terms. **You pay higher copays when you use a specialist without the CCN designation. Not all specialties are included in the CCN. When the specialty is not included in the CCN, the higher Non-CCN copay applies except for therapy & rehabilitation. ***Does not apply to inpatient facility services; subject to applicable place of service co-insurance & plan deductible; Associated ancillary charges are subject to the the applicable place of service co-insurance & deductible. ****Chiropractic visits have a separate 60 visit limit/plan year. Other therapies have a combined 60 visit limit/plan year. 1A limited number of primary care physicians are contracted with CIGNA as specialists; in this case the applicable CCN or Non-CCN specialist copay applies.										